Greg Thigpen, PsyD
Clinical Psychologist
License Psy19198

Child/Adolescent Registration

Date: _____

Client's Name: _____ Date of Birth:_____

Client Cell Phone: (____)_____ Email: _____

Parent/Guardian:_____

Street Address:_____

City: _____

State: _____ Zip: _____

Cell Phone: (_____)_____

Home Phone: (_____)_____

Work Phone: (_____)_____

Parent/Guardian:_____

Street Address:_____

City: _____

State: _____ Zip: _____

Cell Phone: (_____)_____

Home Phone: (_____)_____

Work Phone: (_____)_____

Responsible Party for Billing: _____

Emergency Information:

Contact Name: _____ Relationship: _____

Cell Phone: (____)_____Home Phone: (____)_____Work Phone: (____)_____

Contact Name: _____ Relationship: _____

Cell Phone: (____)_____Home Phone: (____)_____Work Phone: (____)_____

Primary Care Physician: _____Phone: (_____)_____

Address: _____ City: _____State: ____Zip: _____

Current Medications:_____

Allergies: _____

(707) 494 - 6462
www.drthigpen.com
P.O. Box 2996
Santa Rosa, CA 95405

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Agreement for Child/Adolescent Therapy

This agreement is a summary of information provided in Dr. Thigpen's full Agreement for Child/Adolescent Therapy handout. Your signature indicates that you have been offered the opportunity to read the handout, and that you understand the following information.

Evaluation and Treatment by Mutual Consent
Our first few sessions will involve an evaluation, followed by a discussion of how our work together might proceed. Treatment is voluntary and I have the right to discuss how it is proceeding and to seek a second opinion. If I decide I want to speak to another therapist about my concerns, Dr. Thigpen will be willing to provide me the names of other therapists I can speak with.

Fee and Responsibility for Payment:
The hourly fee for my appointment is _____, due and payable by cash or check at the time of my appointment. I (not my insurance company) am responsible for the payment of this fee. This fee reserves Dr. Thigpen's time and I agree that I am responsible for payment, even if I do not show for my appointment, unless I provide 24 hours notice of cancellation. (There may be an exception if Dr. Thigpen and I agree that I was unable to attend due to circumstances beyond my control).

Dr. Thigpen's Availability and Crisis Procedures:
Dr. Thigpen checks his voice mail several times daily during the week, and less often on weekends and holidays. He is available on a brief and occasional basis by phone, longer discussions indicate the need for an appointment to discuss the issues at hand.

If I am in crisis, I can call 911 (for a medical emergency) or Psychiatric Emergency Services, at (707) 576-8181.

Confidentiality and Privilege:
In general, the things I discuss in therapy are confidential (private) and privileged (not to be divulged in a court of law). However, by law there are exceptions. Some circumstances in which a therapist may or must divulge information are (this is not an exhaustive list):

- in cases of child, elder, or dependent adult abuse
- where a client is a danger to self or others
- in some court proceedings (for example, involving child custody or where the client's mental state is at issue).

I also agree that my child is entitled to confidentiality in his/her treatment, and that Dr. Thigpen will provide me with a general overview of treatment themes and progress. In addition Dr. Thigpen will let me know if my child presents a danger to self or others.

I have read, understood, and agree to the terms of the treatment agreement as outlined above.

Client signature: _____ Date: _____

Signature: _____Relation to Client: _____ Date: _____

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